DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-015

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 to 447.299 & 42 CFR 447.321

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $24 million
b. FFY 2004 $24 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Pages 20.12(f), 20.12(f)(1), 20.12(f)(2), 20.12(f)(3)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 20.12(f)

10. SUBJECT OF AMENDMENT:
Outpatient Hospital Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mike Robinson

13. TYPED NAME: Mike Robinson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 9/30/03

16. RETURN TO:
Frances McGraw
Eligibility Policy Branch
Department for Medicaid Services
275 East Main Street 6W-C
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

VIII. Outpatient Hospital Services

A. Effective August 1, 2003, the Department will pay for in-state outpatient hospital services in accordance with the following:

1. Cardiac catheterizations, CT scans, lithotripsies, magnetic resonance imaging, ultrasounds, and observations will be paid at a fixed rate per procedure/service.

   a. The rates for treatment procedures, including cardiac catheterization and lithotripsy, were calculated at 150% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

   b. The rates for diagnostic procedures, including CT scans, ultrasounds, and magnetic resonance imaging were calculated at 100% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

   c. The rate for observation was calculated at 100% of the average adjusted cost for state fiscal years 2000 and 2001.

2. Outpatient services billed with the following revenue codes will be reimbursed on an interim basis by multiplying billed charges by a facility-specific outpatient cost-to-charge ratio:

Service	Revenue Code
Pharmacy	250,251,252,254,255,258,260,261, 634,635,636
X-Ray	320,321,322,323,324,330,342,400, 403,920
Supplies	270,271,272,274,275,621,622,623
EKG/ECG & Therapeutic Supplies	410,412,413,420,421,422,423,424, 440,441,442,443,460,470,471,472, 480,482,510,512,516,517,730,731, 732,740,901,922,940,942,943
Room & Miscellaneous	280,290,370,372,374,700,710,750, 761,890,891,892,893,921
Dialysis	821,831,841
Chemotherapy	330,331,332,333,334,335

a. The cost-to-charge ratio is determined by dividing each hospital's Medicaid costs for providing outpatient services by its Medicaid outpatient billed charges. The cost and charge data will be taken from the most recently audited Medicare cost report.

b. Upon receipt of the audited cost report, payments will be settled to cost at the hospital-specific fiscal year-end.

3. If a service listed in the chart above is provided to the same recipient on the same day as a service listed under subsection 1, it will be included in the fixed rate per procedure.

4. Outpatient surgeries will be grouped according to the 1997 Medicare ambulatory surgical center groups and paid at the following rates which are adjusted to reflect the higher costs associated with providing services in a hospital setting:

Ambulatory Surgical Center Group	Reimbursement Rate
Group 1	$397
Group 2	$534
Group 3	$610
Group 4	$753
Group 5	$858
Group 6	$1,016
Group 7	$1,191
Group 8	$1,191

Surgeries that do not have a group rate will be reimbursed at a facility-specific outpatient cost-to-charge ratio.

5. Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges, with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A. 1 through 4 will be bundled with the fixed rate payment and not reimbursed separately.

6. Emergency room services

   a. The Department will reimburse for emergency room services at a fixed rate per visit based upon the level of service provided. In addition, cardiac catheterization lab, CT Scan, lithotripsy, magnetic resonance imaging, observation, and ultrasound will be paid on a fixed rate basis in accordance with Section A(1).

   b. Services provided in the emergency room will be paid according to three (3) levels of service with a corresponding assessment fee as follows:

      - An assessment, or triage, shall be payable at $20.00.
      - Level I will be those services billed using CPT code 99281, reimbursed at $82.00.
      - Level II will be those services billed using CPT codes 99282 and 99283, reimbursed at $164.00.
      - Level III will be those services billed using CPT codes 99284, 99285, 99291, and 99292, reimbursed at $264.00.

   c. The flat rates per visit were calculated in accordance with the following:

      The Level II rate was calculated by multiplying the average costs for Level II services in state fiscal years 2000 and 2001 (adjusted by the moving average of Data Resources, Inc., for the Hospital Market Basket) by .75.

      The Level I rate was established at 50% of the Level II rate. The Level III rate was established at $100 higher than the Level II rate.

   d. Services listed under Section A(2) will be bundled with the emergency room payment and will not be paid an additional amount. Additional reimbursement will be made for CT Scan, magnetic resonance imaging, observation, ultrasound, lithotripsy, and cardiac catheterization when provided with an emergency room visit at the fixed rate amount.

   e. Thrombolytic agents will be reimbursed at the hospital's acquisition cost.

7. The Department will reimburse state-owned or operated hospitals on an interim basis in accordance with the above provisions with a settlement to actual Medicaid costs at the end of the year.

B. Critical Access Hospitals

1. Outpatient services in a critical access hospital will be exempt from the fixed rate reimbursement system and will be reimbursed on an interim basis by multiplying charges by the lesser of the Medicare cost-to-charge ratio or the Medicaid outpatient cost-to-charge ratio. This interim rate will be settled to cost at the end of the year.

2. Laboratory services provided in a critical access hospital will be reimbursed in accordance with the Medicare fee schedule and settled to cost at the end of the year.

C. Out of State Hospitals

1. Outpatient services which include cardiac catheterization lab, CT Scan, lithotripsy, magnetic resonance imaging, observation, ultrasound, and outpatient surgeries provided by an out-of-state hospital will be reimbursed in accordance with Section A.

2. Outpatient services listed in Section A(2) provided by an out-of-state hospital will be reimbursed by multiplying the average outpatient cost-to-charge ratio of in-state hospitals by the charges billed.

D. Cost Reports

In-state hospitals providing outpatient services will be required to submit a cost report within five (5) months after the hospital's fiscal year end.

E. An emergency room or other outpatient service provided within 3 days of an admission for the same or related diagnosis will be included in the reimbursement for the impatient admission and will be paid in accordance with Attachment 4.19-A.